STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 01 B. WING	06/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/25/13 Facility Number: 000035 Provider Number: 155089 AIM Number: 100266250 Surveyors: Mark Bugni, Life Safety Code Specialist & Robert Sutton, Life Safety Code Specialist Trainee At this Life Safety Code survey, Heritage House of New Castle was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in	K010000	F0000 F0000Preparation and/or execution of This Plan of Correction in generalor any corrective action set forth herein, in particular, does not constitutean admission or agreement by Heritage House of New Castle of the facts allegedor the conclusions set forth in the statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed solely because of provisions of federal and/or state laws. Heritage House desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective July 25, 2013 except for extensions requested on K 062: compliance date August 20, 2013, K 144: compliance date August 25, 2013.This building respectfully requests consideration for paper compliance from the Plan of Correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	all resident sleeping rooms. The facility has a capacity of 95 and had a census of 54 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except the two detached wooden storage sheds. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/27/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 12 hazardous areas, such as a combustible storage room over 50 square feet in size, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 22 residents who reside on the Southeast Hall near the housekeeping storage room. Findings include: Based on observation on 06/25/13 at 11:30 a.m. with the administrator and maintenance director, the door to the Southeast Hall housekeeping storage room, which measured one hundred eighty square feet in size had six shelves of combustible toilet paper, paper towels, and cardboard boxes, failed to close and	K010029	K 029 Heritage House will continue to ensure that doors are self-closing and non-rated or field applied protective plates that do not exceed 48 inches from the bottom are permitted. 1. The door closer to the housekeeping closet that contained combustible toilet paper, paper towels, and cardboard boxes was replaced on July 1, 2013. The housekeeping closet now closes properly. There was no negative outcome affecting any resident due to the door not hutting correctly. 2. No other residents, than the 22 originally identified, reside in this area. 3. The Maintenance Supervisor or his designee will check all doors with automatic closers weekly. 4. The Maintenance Supervisor or his designee will add doors with automatic closers to their weekly	07/25/2013

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	latch into the door frame leaving a one inch gap. Furthermore, the self closing device allowed the door to prop into the open position when the door was opened at the fullest extent. This was verified by the administrator and maintenance director at the time of observation and acknowledged by the administrator at the exit conference on 06/25/13 at 1:45 p.m. 3.1-19(b)		preventative maintenance program. This will be ongoing. Maintenance Dept will report to QA Committee their findings quarterly for 6 months, then as part of their routine report, for review and recommendations. See attachment # 1 A, B, C. Completion July 25, 2013.	

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K010038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 6 of 6 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects all residents in the facility. Findings include: Based on observations during a tour of the facility on 06/25/13 from 10:00 a.m. to 1:45 p.m. with the administrator and maintenance director, all six exit doors were magnetically locked and could be opened by entering a four digit code, but the code was not posted next to each exit door in the facility. Based on interview	K010038	F 038 Heritage House will continue to maintain exit access arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.2 1. The four digit code has been placed at each exit door. Based on resident clinical diagnosis, from resident records from pharmacy, only 4 residents out of 55 residents do not have a clinical diagnosis that requires being in a secure building. Our current policy is to provide each resident who does not have a diagnosis contradicting the necessity of a secure building the door code. This code is also provided during each resident's admission for the family or responsible party. There has been no negative out come from this practice nor any complaints from any resident or their family or responsible party. 2. All residents had the potential to be affected, so no other residents had the potential to be affected. 3. The Maintenance Supervisor or his designee will check the doors that lock magnetically, to ensure the four digit code is in place. 4. The Maintenance Supervisor or his designee will add checking the magnetic door codes to their weekly preventative maintenance	07/25/2013

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	with the administrator during the observations, approximately thirty four of the fifty four residents in the facility do not have a clinical diagnosis to be in a secure building. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code. The lack of the four digit code posted next to each exit door was acknowledged by the administrator at the exit conference on 06/25/13 at 1:45 p.m. 3.1-19(b)		log for 3 months, then to their monthly preventive maintenance log for 3 months. They will report their finding to the QA Committee quarterly for their review and will follow any recommendations. See attachment #2. Completion date 7/25/2013	

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K010052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure the fire alarm system was tested to include the transmission of the fire alarm signal during 4 of 4 third shift fire drills conducted over the past year. NFPA 72, National Fire Alarm Code, in Table 7-3.2, Testing Frequencies at number 23 requires monthly testing of the Supervisory Station Fire Alarm Systems receivers. This deficient practice could affect all residents in the facility. Findings include: Based on review of Fire Drill Reports with the administrator and maintenance director on 06/25/13 at 10:25 a.m., the fire drills conducted on 04/05/13 at 5:15 a.m., 02/13/13 at 6:00 a.m., 10/22/12 at 3:58 a.m., and 08/02/12 at 5:45 a.m. each indicated the drills were a silent alarm with the block for each fire drill indicating "no" to the transmission of the fire alarm signal to the security monitoring company. Based on an interview with the maintenance director	K010052	K 052 Heritage House will continue to provide a fire alarm system as required for life safety that is installed, tested and maintained in accordance with NFPA 70 National Electric Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 1. A new form has been put into place that provides a place to document that the fire alarm system transmission has been tested following all 3 rd shift fire drills that are conducted by a silent alarm. There was no negative out come from the lack of documentation of the fire alarm system transmission. See attachment #3 2. All residents had the potential to be affected, so no other residents had the potential to be affected. 3. The Maintenance Supervisor or his designee will begin using the new form that has a place for documentation that the fire alarm system has been transmitted after each 3 rd shift or silent	07/25/2013

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	on 06/25/13 at 10:55 a.m., the fire alarm system was tested during these third shift monthly fire drills on the following day after the fire drills occurred but not documented. The lack of fire alarm system transmission documentation during the four third shift fire drills over the past year was acknowledged by the administrator at the exit conference on 06/25/13 at 1:45 p.m. 3.1-19(b)		alarm fire drill. 4. The Maintenance Supervisor or his designee will monitor the new fire alarm form monthly for 6 months and report their findings to the QA Committee for their review and recommendations. Completion 7/25/2013	

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K010062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement. Findings include: Based on observation on 06/25/13 at 12:45 p.m. with the administrator and maintenance director, there were ten spare pendant metal fuseable link sprinklers	K010062	K 062 Heritage House will continue to maintain their automatic sprinkler system in reliable operating condition and ensure they are inspected and tested periodically. 1. 1) SafeCare , Indianapolis, IN. has been contacted to bring a minimum of 2 extra sprinkler heads of each type and temperature rating to be available as a replacement in an emergency. 2) SafeCare, Indianapolis, IN. has been contacted to replace or repair the 2 sprinklers with rust in the kitchen walk in cooler. 3) The 3 of over 300 sprinkler heads in the facility have had the escutcheons repaired to be flush with the ceilings, by the Maintenance Supervisor on July1, 2013. There was no negative outcome from the above items affecting any resident. 2. All residents in the building had the potential to be affect by the practices listed in #1. Only the noted 24 residents who eat in the dinning room had the potential to be affected by #2. As only 3 sprinkler heads out of more than 300 in the building had	08/14/2013

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	with a one hundred sixty five degree temperature rating in the spare sprinkler cabinet located in the Center Hall sprinkler riser room. During a tour of the facility on 06/25/13 from 10:00 a.m. to 1:45 p.m. with the administrator and maintenance director, red liquid filled sprinklers with a one hundred sixty five degree temperature rating were observed mixed with metal fuseable link sprinklers in all resident rooms and all corridors in the facility. Furthermore, metal sidewall mounted sprinklers were observed in the sprinkler riser room and in the Northeast Hall electric room. The lack of two red liquid filled sprinklers with a one hundred sixty five degree temperature rating and two sidewall sprinklers in the spare sprinkler cabinet was acknowledged by the administrator at the exit conference on 06/25/13 at 1:45 p.m. 3.1-19(b) 2. Based on observation and interview, the facility failed to replace 2 of 2 sprinklers covered in rust in the kitchen walk in cooler and refrigerator. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998		escutcheons not flush with the ceiling no other residents had the potential to be affected. The repairs listed as # 1, #2, or #3 above, are the needed corrective action. 3. The Maintenance Supervisor or his designee will add: 1) checking the spare sprinkler heads to ensure the correct type and temperature are available to their weekly preventative maintenance checks for 3 months, monthly for 3 months, then as needed. 2) The sprinkler heads in the kitchen walk in coolers will be checked weekly for 3 months, monthly for 3 months, then as needed. 3) The sprinkler heads escutcheons will be checked weekly for 3 months, monthly for 3 months, then as needed. Monthly inspection of all sprinkler heads is done to ensure they are in reliable operating condition, ongoing. See Attachments 1A. #4 4. The Maintenance Supervisor or his designee will report results of the weekly checks, monthly checks, and as needed checks for the above noted #1, #2, and #3 to the QA Committee for review and recommendations. We are requesting an extension of 20 days, for the correction of #2. See attachment #4. SafeCare is unable to come to the facility before July 15, 2013 to measure the sprinkler heads in the walk in cooler for repair or replacement. They have informed us the expected delivery of parts	

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	edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 24 residents who use the main dining room, located adjacent to the kitchen. Findings include: Based on observation on 06/25/13 at 11:05 a.m. with the administrator and maintenance director, the sprinkler in the kitchen walk in cooler and the sprinkler in the walk in freezer were both completely covered in brown rust. This was verified by the maintenance director at the time of observation and acknowledged by the administrator at the exit conference on 06/25/13 at 1:45 p.m. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 3 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect 4 residents who reside in resident room 6 and resident room 7, and the remaining 20 residents who reside on the Northeast Hall. Findings include:		will be three weeks from July 15, 2013. They will then also have to schedule a return visit to replace or repair the sprinkler heads in the walk in cooler. Completion date August 14, 2013.	

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	Based on observations on 06/25/13 during a tour of the facility with the maintenance director from 10:00 a.m. to 1:45 p.m., the following areas had sprinkler head escutcheon not flush to the ceiling leaving between a one half inch and one inch gap into the attic space above; in the shared bathroom between resident room 6 and resident room 7, in the Northeast Hall corridor by resident room 6 and resident room 7, and in the director of nursing office. This was verified by the maintenance director at the time of observations and acknowledged by the administrator at the exit conference on 06/25/13 at 1:45 p.m. 3.1-19(b)			

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K010067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the facility failed to ensure 44 of 44 resident rooms and 4 of 4 resident room egress corridors were not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a potion of a supply return or exhaust air system serving adjoining areas. This deficient practice affects all resident in the facility. Findings include: Based on observations on 06/25/13 during a tour of the facility from 10:00 a.m. to 1:45 p.m. with the administrator and maintenance director, all forty four resident rooms in the facility used the four resident room egress corridors as a return air system for the air conditioning system in the facility. Based on an interview with the maintenance director on 06/25/13 at 10:45 a.m., the resident rooms in the facility are set up with a forced air	K010067	K 067 The Heritage House of New Castle respectfully requests a waiver for this finding. Smoke detectors are located in the areas identified in this finding. Activation of the fire alarm system will trigger relays that shut down the air handlers in these portions of the building. Once the air handler is closed, smoke will be prevented from transferring from one smoke zone to another. Modifications to the existing air handling system will pose a hardship for residents displaced during the installation process. The facility would also incur financial hardship for an estimated cost of $45,000 conservatively to upgrade the air handling system to meet this requirement. The history of the facility reflects no incidents resulting from this finding. See waiver request Attachment #6 A, B, C, D, and E. Completion Date: 7/25/2013	07/25/2013

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	conditioned system through duct work into each resident room with the return through the exhaust vent in each resident room's shared bathroom. Heat is through radiated coils in the resident room drywall ceiling. Furthermore, based on observation of the resident room bathrooms during a tour of the facility with the administrator and maintenance director on 06/25/13 from 10:00 a.m. to 1:45 a.m., each resident room had a shared bathroom with an adjoining resident room and each shared bathroom had a door leading into the bathroom from the resident room. The bathroom vents were also on an electric switch that could be turned on and off by each resident. The lack of a return air duct in each of the forty four resident rooms was verified by the maintenance director at the time of observations and acknowledged by the administrator at the exit conference on 06/25/13 at 1:45 p.m. 3.1-19(b)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciators was provided with the indication of an alarm condition for the battery charger malfunctioning, low water temperature, excessive water temperature, overcrank, and overspeed. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature.	K010144	K144 Heritage House will continue to inspect the generator weekly and exercise under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1 1. The remote alarm annunciator for the generator which is located at the South Nurses Station will be repaired after it is determined what parts are needed. Parts will need to be ordered and installed. Custom Power Services, New Castle, IN. has been hired to do the repairs along with the local Authorized Generac Power Systems Dealer, who installed the generator. Initial visit was July 11, 2013. The repairs will include a visual and audible alarm system. The system will include a derangement signal that shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110:3-5.5.2]. We were informed by the Life Safety Code Supervisor that this is acceptable. There have been no negative affects to any resident, staff or visitor. 2. All resident, staff, or visitors could have been affected. No others residents can be identified.	08/25/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 01 B. WING	06/25/2013

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	4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all the residents as well as visitors and staff. Findings include: Based on observation on 06/25/13 at 12:45 p.m. with the administrator and maintenance director, the remote alarm annunciator for the generator, which was located at the Northeast Hall nurses' station, was only provided with a visual and audible alarm signal for generator running and normal power. The remote alarm annunciator lacked the indication of an alarm condition for the battery charger malfunctioning, low water temperature, excessive water temperature, overcrank, and overspeed. This was verified by the administrator and maintenance director at the time of observation and acknowledged		3. Maintenance Supervisor or his designee will monitor the audible and derangement signal weekly for 6 months and on going. Staff will be inserviced on audible and derangement signal after repair is completed. 4. Maintenance Supervisor or his designee will monitor the audible and derangement signal panel weekly for 6 month and ongoing. They will report their findings to the QA Committee for review and recommendations. Attachment #7. We are requesting a 30 day extension for this tag, due to the fact that parts must be ordered and installed. Completion date 8/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 01 B. WING	06/25/2013

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	by the administrator at the exit conference on 06/25/13 exit conference at 1:45 p.m. 3.1-19(b)			